**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

HOUSTON COMMUNITY HOSPITAL
PO BOX 11586
HOUSTON TX 77293

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

**Respondent Name**
FIREMANS FUND INSURANCE CO

**Carrier's Austin Representative Box**
Box Number 19

**MFDR Tracking Number**
M5-04-3884-01

**MFDR Date Received**
JUNE 25, 2004

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary as stated on the Table of Disputed Services:** "Carrier did not pay our claims at the usual and customary. HCH is requesting that our claims be processed at the usual and customary."

**Amount in Dispute:** $ 9,029.36

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The billing in dispute has been paid at a fair and reasonable rate in accordance with TWCC guidelines, policies and rules, and the Texas Labor Code. Carrier has determined that $1,423.64 represents an amount greater than or equal to the fair and reasonable reimbursement for this service. The provider must therefore prove that the reimbursement received is not fair and reasonable… Because requestor has failed to prove that reimbursement received is not fair and reasonable, Requestor is not entitled further reimbursement."

**Response Submitted by:** Flahive, Ogden & Latson, PO Drawer 13367, Austin, TX 78711

## *SUMMARY OF FINDINGS*

| Date(s) of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| October 23, 2003 | Outpatient Hospital Services | $9,029.36 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

4. This request for medical fee dispute resolution was received by the Division on June 24, 2004. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on August 12, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - M – No MAR
   - 360 – Allowance for this procedure was made at the "fair and reasonable" amount for this geographical area.
   - 419 – Reductions are due to charges exceeding amts reasonabl3e for provider's demographic area.
   - C – Negotiated Contract
   - U – Unnecessary treatment (w/o peer review)
   - F – Fee guideline MAR reduction
   - 270 – No allowance has been recommended for this procedure/service/supply please see special *note* below.
   - 375 – Please see special *note* below
   - *Note* - Please see attached letter of re-evaluation for case #286097

**Findings**

1. The insurance carrier reduced or denied disputed services with reason code C – "Negotiated Contract." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. The carrier denied services using the denial code U - "Unnecessary treatment (w/o peer review)." In accordance with Texas Administrative Code Section 133.301(a), which states in part, "The insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization under Chapter 134..." The health care provider submitted a copy of the preauthorization approval number 1107693. The above denial reason is not support. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
3. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. 28 Texas Administrative Code §133.307(g)(3)(C)(i), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "a description of the healthcare for which payment is in dispute." Review of the submitted documentation finds that the requestor did not provide a description of the healthcare for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(i).
6. 28 Texas Administrative Code §133.307(g)(3)(C)(ii), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "the requestor's reasoning for why the disputed fees should be paid." Review of the submitted documentation finds no documentation of the requestor's reasoning for why the disputed fees should be paid. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(ii).
7. 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 Texas Register 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iv).

8. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's rationale for increased reimbursement from the *Table of Disputed Services* asserts that "HCH is requesting that our claims be processed at the usual and customary"
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | October 26, 2012<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.